

Claims and ICD-10

Claim Forms

Paper Claim Forms

CMS1500 professional claim form

- www.nucc.org

UB-04 institutional claim form

- www.nubc.org

Both claim forms

- www.cms.hhs.gov

Includes field definitions and valid data for all fields

Professional Claim: CMS 1500



The image shows a pair of glasses resting on a CMS 1500 Health Insurance Claim Form. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes various fields for patient and insured information. The form is partially filled out, with some fields containing text and others containing checkboxes. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes various fields for patient and insured information. The form is partially filled out, with some fields containing text and others containing checkboxes. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes various fields for patient and insured information. The form is partially filled out, with some fields containing text and others containing checkboxes.

HEALTH INSURANCE CLAIM FORM

1. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAMPVA (VA File #) CHAMPVA (VA File #) CHAMPVA (VA File #)

2. PATIENT'S ADDRESS (No., Street) CHAMPVA (VA File #) CHAMPVA (VA File #) CHAMPVA (VA File #)

3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F) OTHER (RD)

4. INSURED'S NAME (Last Name, First Name, Middle Initial) (FOR PROGRAM)

5. INSURED'S I.D. NUMBER

6. PATIENT STATUS (Self, Spouse, Child, Other) (RD)

7. EMPLOYMENT? (CURRENT OR PREVIOUS) (YES/NO)

8. AUTO ACCIDENT? (YES/NO)

9. OTHER ACCIDENT? (YES/NO)

10. IS PATIENT'S CONDITION RELATED TO (a) EMPLOYMENT? (b) AUTO ACCIDENT? (c) OTHER ACCIDENT?

11. INSURED'S POLICY NUMBER (GROUP OR FECA NUMBER)

12. INSURED'S DATE OF BIRTH (MM/DD/YY)

13. INSURED'S SEX (M/F)

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO)

16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or hospital for services described below.)

17. DATE (MM/DD/YY)

18. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

19. DATE (MM/DD/YY)

20. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

21. DATE (MM/DD/YY)

22. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

23. DATE (MM/DD/YY)

24. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

25. DATE (MM/DD/YY)

26. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

27. DATE (MM/DD/YY)

28. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

29. DATE (MM/DD/YY)

30. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

31. DATE (MM/DD/YY)

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33. DATE (MM/DD/YY)

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35. DATE (MM/DD/YY)

36. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

37. DATE (MM/DD/YY)

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39. DATE (MM/DD/YY)

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41. DATE (MM/DD/YY)

42. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

43. DATE (MM/DD/YY)

44. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

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53. DATE (MM/DD/YY)

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57. DATE (MM/DD/YY)

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69. DATE (MM/DD/YY)

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75. DATE (MM/DD/YY)

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77. DATE (MM/DD/YY)

78. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

79. DATE (MM/DD/YY)

80. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

81. DATE (MM/DD/YY)

82. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

83. DATE (MM/DD/YY)

84. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

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89. DATE (MM/DD/YY)

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93. DATE (MM/DD/YY)

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97. DATE (MM/DD/YY)

98. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

99. DATE (MM/DD/YY)

100. PHYSICIAN'S SIGNATURE (I certify that the services described above were rendered to the insured on the date indicated.)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | | | |
|---|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> PICA | | <input type="checkbox"/> <input type="checkbox"/> PICA | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID) | | 1a. INSURED'S I.D. NUMBER (For Program in item 1) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE | |
| | | 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i> | |

Basic Requirements

- Client name
- Client ID (field 10d)

Conditional Fields

- Other insurance

| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. | | | |
|---|----------------|--|--------------|
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| SIGNED _____ DATE _____ | | SIGNED _____ | |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | MM DD YY | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE | MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. _____ | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | |
| | 17b. NPI _____ | FROM MM DD YY TO MM DD YY | |
| 19. RESERVED FOR LOCAL USE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | |
| | | FROM MM DD YY TO MM DD YY | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ | |
| 1. _____ 3. _____ | | 22. MEDICAID RESUBMISSION | |
| 2. _____ 4. _____ | | CODE _____ ORIGINAL REF. NO. _____ | |
| | | 23. PRIOR AUTHORIZATION NUMBER _____ | |

Basic Requirements

- ICD-9 codes

Conditional Fields

- Referring NPI
- Passport
- Prior Authorization

| 24. A. DATE(S) OF SERVICE | | | | | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. EPIDT Family Plan | I. ID QUAL | J. RENDERING PROVIDER ID # |
|---------------------------|----|----|----|----|----|----|----|--|--|---------------------|--------|--|----------------------|---------------|------------------|----------------------|------------|----------------------------|
| From | To | MM | DD | YY | MM | DD | YY | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | | | NPI | |

| | | | | | | | | | | | | | |
|---|--|--------------------------|--------------------------|---|--|--|--|--------------------------------------|--|-----------------|--|-----------------|--|
| 25. FEDERAL TAX I.D. NUMBER | | SSN | EIN | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? <small>or gov. claim, see back</small> | | 28. TOTAL CHARGE | | 29. AMOUNT PAID | | 30. BALANCE DUE | |
| | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | \$ | | \$ | | \$ | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | 33. BILLING PROVIDER INFO & PH # () | | | | | |
| SIGNED | | | | DATE | | | | a. NPI | | b. | | a. NPI | |

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PHYSICIAN OR SUPPLIER INFORMATION

Basic Requirements

- Date of service
- Place of service
- Procedure codes
- Diagnosis pointer
- Usual and customary charges

| 24. A. DATE(S) OF SERVICE | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. EPISIT Family Plan | I. ID QUAL | J. RENDERING PROVIDER ID # |
|---------------------------|----|----|----|----|----|---------------------|--------|---|--|-------------------------|---------------|------------------|-----------------------|------------|----------------------------|
| MM | DD | YY | MM | DD | YY | | | | | | | | | | |
| 1 | | | | | | | | | | | | | NPI | | |
| 2 | | | | | | | | | | | | | NPI | | |
| 3 | | | | | | | | | | | | | NPI | | |
| 4 | | | | | | | | | | | | | NPI | | |
| 5 | | | | | | | | | | | | | NPI | | |
| 6 | | | | | | | | | | | | | NPI | | |

| | | | | | | | |
|---|--|--|---|--|--------------------------------------|-----------------------|-----------------------|
| 25. FEDERAL TAX I.D. NUMBER | | SSN EIN <input type="checkbox"/> <input type="checkbox"/> | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? <small>if or govt. claim, see back</small> <input type="checkbox"/> YES <input type="checkbox"/> NO | 28. TOTAL CHARGE \$ | 29. AMOUNT PAID \$ | 30. BALANCE DUE \$ |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | 32. SERVICE FACILITY LOCATION INFORMATION | | 33. BILLING PROVIDER INFO & PH # () | | |
| SIGNED _____ DATE _____ | | | a. NPI | b. | a. NPI | b. | |

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PHYSICIAN OR SUPPLIER INFORMATION

Basic Requirements

- Units
- Rendering Provider NPI/Taxonomy
- Authorized signature and date
- Total charges
- Montana Health Care Programs NPI (field 33a) and Taxonomy (field 33b)

| | | | |
|---|--------------------------------------|---|--------------------------------------|
| PICA | | PICA | |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | | 7. INSURED'S ADDRESS (No., Street) | |
| 5. PATIENT'S ADDRESS (No., Street) | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY | STATE | CITY | STATE |
| ZIP CODE | TELEPHONE (Include Area Code) () | ZIP CODE | TELEPHONE (Include Area Code) () |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | |
| b. RESERVED FOR NUCC USE | | b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i> | |
| 8. RESERVED FOR NUCC USE | | 10d. CLAIM CODES (Designated by NUCC) | |
| a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ | |
| c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

PATIENT AND INSURED INFORMATION

CMS 1500 Proposed Changes

- Field 8 reserved for NUCC use

| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. | | | |
|--|---------------------------------------|---|--|
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| SIGNED _____ DATE _____ | | SIGNED _____ | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____ | 15. OTHER DATE QUAL _____ MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE □ _____ | 17a. _____ 17b. NPI _____ | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ | | 22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ | |
| A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ | | 23. PRIOR AUTHORIZATION NUMBER _____ | |

CMS 1500 Proposed Changes

- Diagnosis fields increased to 12
- Hold up to 7 characters

| 24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # | | |
|---|--|--|--|--|--|---|--------|---|--|--|---------------|--------------------------------------|----------------------|-----------------------|-----------------------------|-----------------------|--|
| | | | | | | | | | | | | | | NPI | | | |
| | | | | | | | | | | | | | | NPI | | | |
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| | | | | | | | | | | | | | | NPI | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | | SSN EIN | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28. TOTAL CHARGE \$ | | 29. AMOUNT PAID \$ | | 30. Rsvd for NUCC Use | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | 33. BILLING PROVIDER INFO & PH # () | | | | | |
| SIGNED | | | | | | DATE | | | | | | a. NPI | | b. NPI | | | |

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE OMB APPROVAL PENDING

PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500 Proposed Changes

- Field 30 reserved for NUCC use

Institutional Claim: UB-04



| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----|-------------------|---|----------------------------|-----------|-------------------------|---|-------------------------|---|-------------------------|--|----|----|---|---|---|---|---|---|---|---|----|---|---|---|---|---|---|---|---|---|--|--|
| 50 PAYER NAME | | 51 HEALTH PLAN ID | | 52 REL INFO | 53 AS BEN | 54 PRIOR PAYMENTS | | 55 EST. AMOUNT DUE | | 56 NPI | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 57 OTHER PRV ID | | | | | | | | | | | | | | | | | | | | | | | |
| 58 INSURED'S NAME | | 59 P REL | | 60 INSURED'S UNIQUE ID | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | | | | 64 DOCUMENT CONTROL NUMBER | | | | 65 EMPLOYER NAME | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>66</td> <td>67</td> <td>A</td> <td>B</td> <td>C</td> <td>D</td> <td>E</td> <td>F</td> <td>G</td> <td>H</td> <td>68</td> </tr> <tr> <td>1</td> <td>J</td> <td>K</td> <td>L</td> <td>M</td> <td>N</td> <td>O</td> <td>P</td> <td>Q</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | | | 66 | 67 | A | B | C | D | E | F | G | H | 68 | 1 | J | K | L | M | N | O | P | Q | | |
| 66 | 67 | A | B | C | D | E | F | G | H | 68 | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | J | K | L | M | N | O | P | Q | | | | | | | | | | | | | | | | | | | | | | | | | |
| 74 PRINCIPAL PROCEDURE CODE | | 75 REASON CODE | | 76 OTHER PROCEDURE CODE | | 77 OTHER PROCEDURE CODE | | 78 OTHER PROCEDURE CODE | | 79 OTHER PROCEDURE CODE | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 80 REMARKS | | | | 81 CC | | 82 | | 83 | | 84 | | | | | | | | | | | | | | | | | | | | | | | |
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UB-04 CMS-1450 © 2005 NUBC

CMS APPROVAL PENDING

NUBCSM National Uniform Billing Committee LJC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Basic Requirements

- Payer name
- Pay-to NPI (form locator 56)
- Client Name
- Client ID
- Primary diagnosis
- Attending provider NPI and Taxonomy

UB-04

Conditional information

- Admission (inpatient)
- Condition codes
- NDC
- Service dates
- Treatment authorization
- Admitting diagnosis (inpatient) EMG
- Unlabeled (73) cost share indicator
- ICD-9 (inpatient only)
- Operating and other provider

Dental Claim



Dental

Basic Requirements

- 2006 ADA form
- Complete the form in full
- Instructions can be found at
 - <http://www.ada.org>

Conditional Requirements

- Other coverage
- Orthodontics

Electronic Claims

Ways to submit claims

- Practice management software
- Billing agent
- Clearinghouse
- WINASAP5010 software

Electronic Billing Processing

- Upload electronic claims
- HIPAA 5010 format
- Screened for Montana specific edits
- Accepted, Rejected, or Errored out

Common Questions

- Where do I find Montana specific electronic billing information?
- What is X12?
- What is the payer ID?
- When do claims cycle?
- Where is my EOB?

WINASAP5010

- Free software developed by Xerox
- Support offered by Xerox EDI: 800-624-3958
- Submit all claim types
 - Institutional
 - Professional
 - Nursing Home
 - Dental

Common WINASAP Questions

- Does Xerox keep a backup of my WINASAP files?
- Will WINASAP work with Microsoft Windows 8?
- Was my electronic file received?
- Why do the same claims keep processing?

Remittance Advice

Available every Tuesday

- Web portal
 - www.mtmedicaid.org
 - Available 90 days
 - Save or print option
- 835 transaction
 - ANSI X12 format
 - Practice Management software conversion
 - Offered via clearinghouse

Remittance Advice

Tips

- Visit the EOB R&R crosswalk
- Work all denials before resubmitting
- Do not post payments in a credit balance
- Do not resubmit claims in a Pended status

Remittance Advice

```
1234567      Data, Test          07012011 07012011  1.000 99221 204.00   96.66
      ICN 21122000000000000000 PATIENT NUMBER=10000
```

0000111111 Fred T Flinstone M D

| | | | | | | | |
|----------|----------|-------|-------|---------|------|-----|-----------------|
| 07022011 | 07022011 | 1.000 | 59514 | 1900.00 | 0.00 | B22 | B13 M86 B15 M80 |
| 07032011 | 07032011 | 1.000 | 99231 | 93.00 | 0.00 | B22 | |
| 07042011 | 07042011 | 1.000 | 99238 | 154.00 | 0.00 | B22 | |

THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE **

B13 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED
IN A PREVIOUS PAYMENT.

B15 PAYMENT ADJUSTED BECAUSE THIS PROCEDURE/SERVICE IS NOT PAID
SEPARATELY.

B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.

MA04 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR
PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER
NOT REPORTED OR WAS ILLEGIBLE.

M80 NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.

M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE
WITHIN SET TIME FRAME.

N286 MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.

107 CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE
WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

15 THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE
BILLED SERVICES OR PROVIDER.

18 DUPLICATE CLAIM/SERVICE.

22 THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.

9 THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.

ICD-10

- What is the ICD-10 implementation date?
- Where do I find information about ICD-10?

Contact Information

Denise Juvik Field Representative

Phone 406-457-9598

Denise.juvik@xerox.com

Danielle Wood Field Representative

Phone 406-457-9553

Danielle.wood@xerox.com

Questions?